Vol. XXVII TORONTO, CANADA, JUNE, 1925 No. 6

The Official Organ of the Provincial Hospital Associations

The HOSPITAL MEDICAL and NURSING WORLD

CONTINUING THE HOSPITAL WORLD

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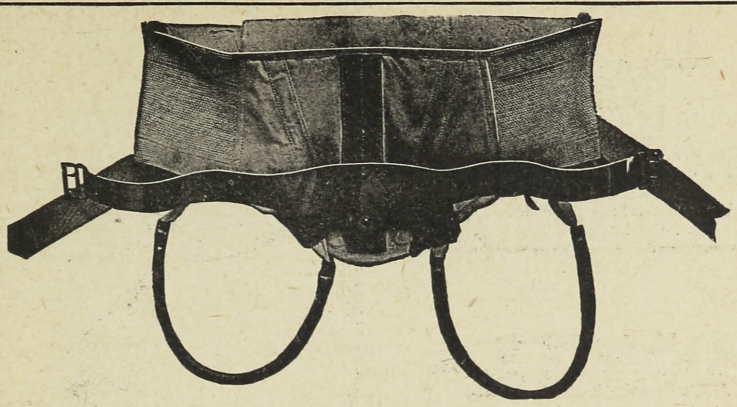
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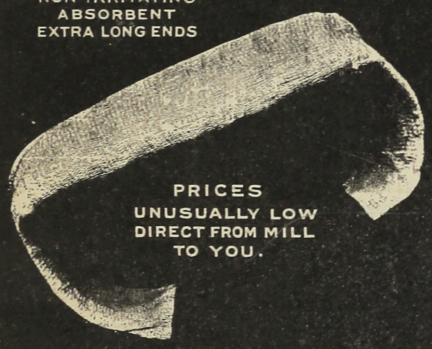
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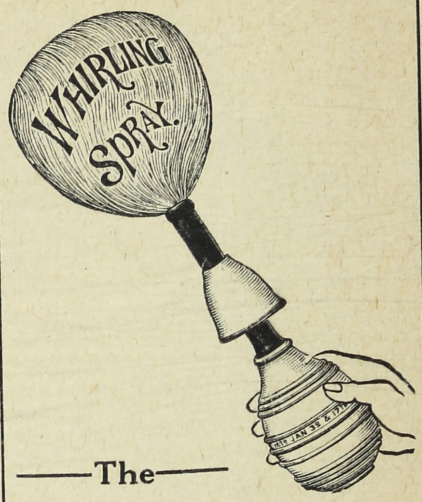
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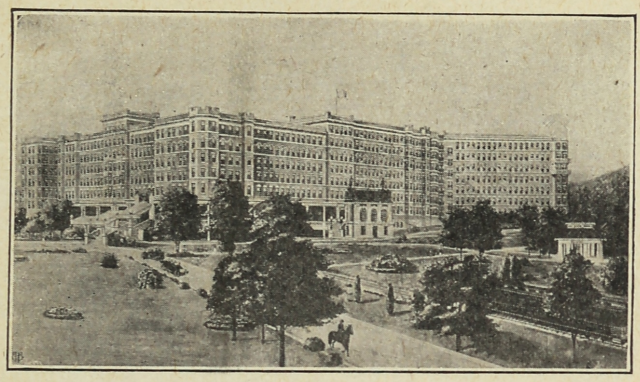
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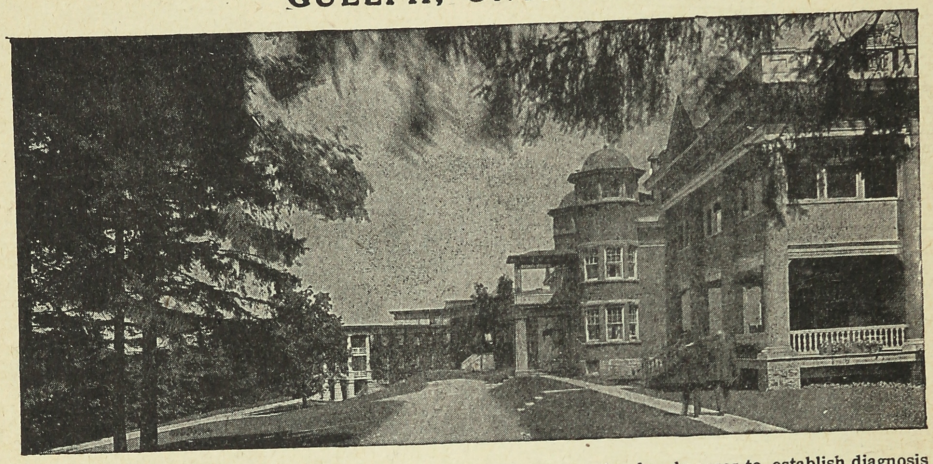
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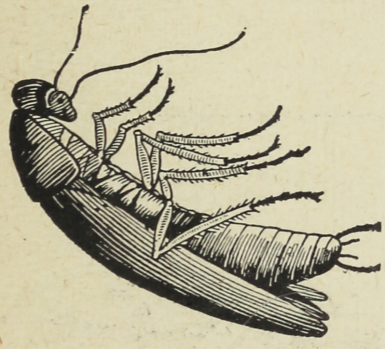
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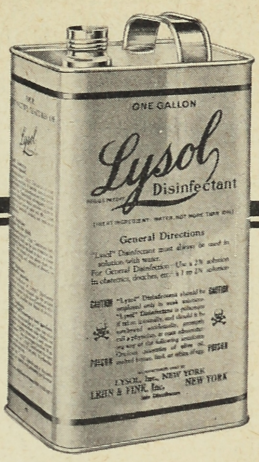
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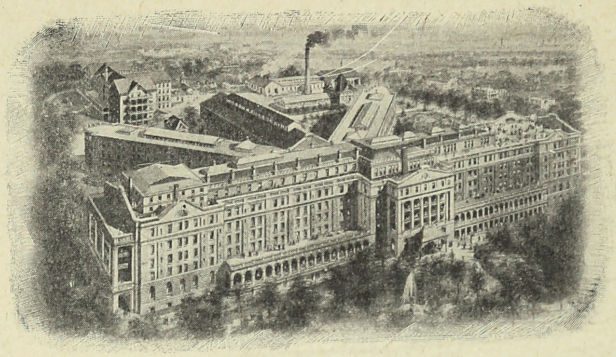
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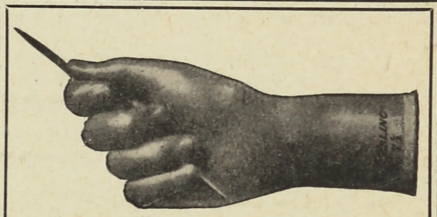
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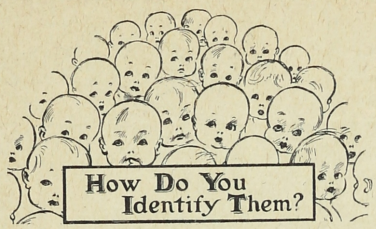
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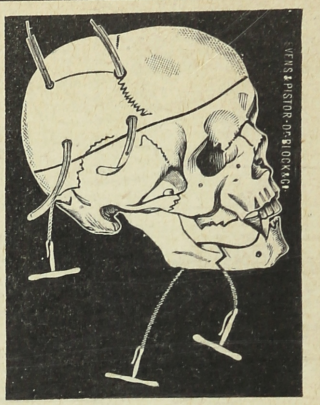
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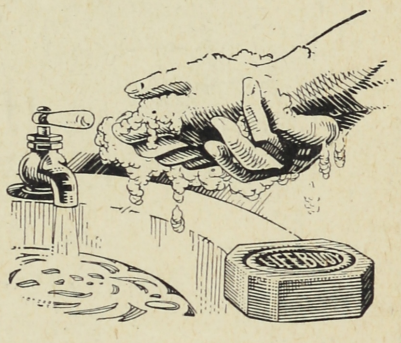
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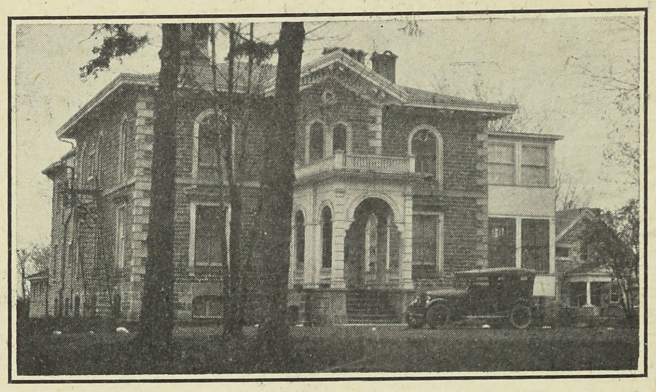
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VOL. XXVII TORONTO, JUNE, 1925 No. 6

Editorial

Hospital Histories

One oracle has made the pronouncement that the careful history of the patient gives us eighty per cent. of the diagnosis; another has said the first and big thing in treatment is the diagnosis. So the history has a double importance.

A few years ago when the surgeons of America allowed their consciences to act, they formulated standards for hospitals, and under cover of this category condemned fee splitting, which has always seemed to the writer a peculiar item for inclusion under hospital standardization. The other requirements were altogether fitting: History taking, staff conferences, adequate laboratories, and more autopsies—and the greatest of these is history taking.

The taking of histories falls upon the internes for the most part. These histories should be read and vised by the attending physician or surgeon. They should be complete, including progress notes and final outcome of the case. If death ensues a report

of the post-mortem should be attached, where operation is performed a description of the operation and of the findings should be incorporated in the history. A comparison should be made between what is found at operation and at autopsy with what was diagnosed. The pathologist should check up the work of the clinician.

Staff conferences have done much to improve history taking, because in these conferences unsuccessful cases have been discussed and to discuss such intelligently good histories are necessary.

Some staffs have special committees on histories —a good scheme. And at the staff conference imperfect or incomplete histories are presented and clinician and house doctors are kindly brought to book.

Of all the points taken up by the College of Surgeons that which has been of greatest importance, we think, has been that of the emphasis on proper histories.

Certain hospitals have failed in the matter of histories through shortage of house officers. The time is arriving when hospitals will be obliged to have a satisfactory complement of these young graduates and may even have to pay them for their work; and not the least important of their work is the taking of histories.

It should be needless to add that histories after being taken should be properly filed and taken care of and if one is needed at any time its production should be possible on a minutes' notice.

An Addiction Hospital

It is reported that there are thousands of drug addicts in Canada. What is to be done with them? And what is to be done about the dope? The League

of Nations is dealing with the manufacture and sale of opium. Canada has a law on the importation, prescription and use of opium and its derivatives, cocaine, etc. It is important that this law should be properly enforced and that public sentiment in Canada should strongly endorse the ideal of the American representatives on the League, who in as short a time as possible wish to prohibit the raising of the poppy except for the supplying of such an amount of opium as is necessary for medicinal use.

Now as to the addicts: These pitiable mortals can only be treated in a hospital—preferably in a separate building or separate division of a public hospital. They should be segregated from other patients. We believe it requires a doctor of special capacity and training to handle these patients and treat the disease. No specially constructed building is needed. A hydro-therapeutic room, with electricity and massage are valuable adjuncts, but not absolutely necessary. Careful nursing is needed.

Patients on admission should be stripped in a retiring room, bathed and their persons searched for dope—hair, nostrils, external auditory meatuses and rectum, to ascertain if they have any concealed. They are then passed to a room or ward—single preferably—and kept alone, unvisited by friends or relatives for at least ten days, unless in case of necessity, and then only by those whom the attendants are sure are not carrying dope. For the addicts, all moral sense being obtunded, will lie and steal—do anything to get the cursed stuff.

Withdrawal should be comparatively slow—depending on the addict's physical condition, the amount he takes *per diem* and the length of his addiction.

The emunctories—particularly the bowels—are to be kept freely opened. Supporting treatment is administered and such drugs as belladonna, hyoscyamine, scopalomine and the like given in full doses, but under very careful supervision.

We daresay a house of twenty beds might serve Toronto or Montreal. A ten-bed in Halifax for the Maritime provinces. A fifteen-bed in Winnipeg for Manitoba. A ten or fifteen-bed near the boundary between Saskatchewan and Alberta, for those two provinces, and a small one in Vancouver. A survey would tell.

These suggestions and others pertinent to the subject might be discussed at the coming meetings of the Canadian and Provincial Medical Association and the result of their deliberations passed on to the Dominion and Provincial Boards of Health for action.

Duties of the Medical Staff

In our larger hospitals it is very important that attending staff and house staff work harmoniously. Their duties should be well defined so that the patient will receive all the attention he needs from both.

To this end it is advisable that house officers make a complete physical examination of all patients and write a history of their cases within twenty-four hours of admission. A routine urinalysis should be made in every case, and a white blood count made in all patients suspected of suffering from pneumonia, appendicitis, typhoid fever and in other conditions if desired by the attending physician or surgeon. Daily progress notes should be made in all cases of patients acutely

ill. A provisional diagnosis should be made by the house doctor and recorded on a slip which may be temporarily attached to the history file.

Each history should be signed by the house man with his full name—not merely initialled.

In all cases admitted through the emergency department the general history should be completed, and include the emergency record.

As to the visiting staff, they should check all histories and physical examinations of patients under their care which have been made by their respective house men. They should record the important reasons justifying their diagnosis and advice. Surgeons should make complete notes of their operation findings. Visiting doctors should make or have made adequate progress and dismissal notes, and check the internes' progress notes.

At the monthly staff meetings all incomplete histories should be reported, and house men and attending physicians enjoined to have them completed.

That patients may secure prompt attention, it is desirable that the admitting clerk immediately notify the interne concerned or his deputy of the admission of any patient into his wards. The interne should examine the new patient at once, and after noting the main points in the case, communicate them at once to his chief. If the patient is severely ill he should not rest satisfied until he has got in touch with his chief and received instruction what to do. Failing to reach his chief he should report to the chief's assistant or deputy, and failing to reach any of them (say, through their absence from office) he should report the case to the senior house surgeon for advice. Of course, where there is a capable admitting doctor or a doctor for the day, the interne

may be relieved of such notifications; for in that case we assume the admitting officer will communicate his findings to the attending doctor.

Where the resident system is in vogue and men of several years' experience are on duty the above precautions are not so incumbent on internes; for they can usually consult with a resident about the newly admitted patient.

Strict observance of these suggestions will do much to enhance the reputation of any hospital. There is no advertisement so good as a satisfied patient.

Rectal Anesthesia in Obstetrics

Gwathmey's method of inducing anesthesia in labor is being tried out in certain Toronto hospitals.

The method consists in two operations: first, when labor has well set in—contractions occurring every four to six minutes and lasting one minute—a hypodermic of morphia, gr. 1/6 along with two centimetres of a fifty per cent. solution of magnesium sulphate, is injected deeply into arm, leg or abdominal wall. Superficial injections have been known to cause necrosis. The Epsom salts have the peculiar property of enhancing the analgesic power of other drugs.

The next procedure is to clear out the large bowel by a high enema until the fluid returns clear.

The mixture for injection into the bowel consists of 20 grains of quinine hydrobromide dissolved in two drachms of alcohol, which is added to two ounces of ether and enough olive oil to produce four ounces. The oil prevents the ether from unduly irritating the bowel wall. There may be a desire for a minute or so on the part of the patient to defecate, but this

must be withstood. Indeed, the whole process should be explained to the patient so that she will intelligently co-operate with doctor and nurses.

The mixture is poured through a funnel, connected with a rubber tube, united with the rectal catheter by means of a connecting tube. A clamp for the tube may be used or the fluid may be shut off with the fingers in case the contractions come on and necessitate waiting and also when the injection is complete. Care must be taken not to allow air to get into the rectum.

In a few minutes the patient may taste the ether, so quickly is it absorbed into the system, and in ten minutes she is usually asleep. Contractions go on as frequently and as forcibly as before. The anesthesia lasts from two to six hours, depending upon the susceptibility of the patient and the way the injection is retained.

As might be predicted, the ether makes some patients much excited, even hallucinated, and violent; hence for a short period difficult to handle. Therefore, such patients had better be confined in a hospital than in the home. Besides, a careful and competent nurse must be in attendance constantly to prevent any mishap, such as the falling of the tongue back into the throat, thus embarrassing the breathing.

Again, the new born babe must be examined particularly to see if it has absorbed too much of the morphia. If there be signs of narcotism suitable stimulation must be given forthwith.

This method is being enthusiastically used in one of the large Toronto hospitals with apparent fine success; in another it has been tried, but the obstetrical men seem to think it desirable to hasten slowly.

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(Continuing the Hospital World)

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Canadian Hospitals

AN APPROVED CANADIAN HOSPITAL THAT GREW OUT OF AN EMERGENCY*

St. Joseph's General Hospital in Port Arthur, Ontario, dates back to the year 1881, when six Sisters left their mother-house in Toronto for Port Arthur, to offer their self-sacrificing service in educating the children of the scattered pioneers of that new country.

In those early years the Canadian Pacific railway was in the course of construction, resulting in a great influx of people without established homes. There had not been any proper accommodation provided for those overtaken by accident or disease, and it was not long before a widespread epidemic of typhoid fever broke out and the hotels and few private homes of the town were filled to overflowing with the sick.

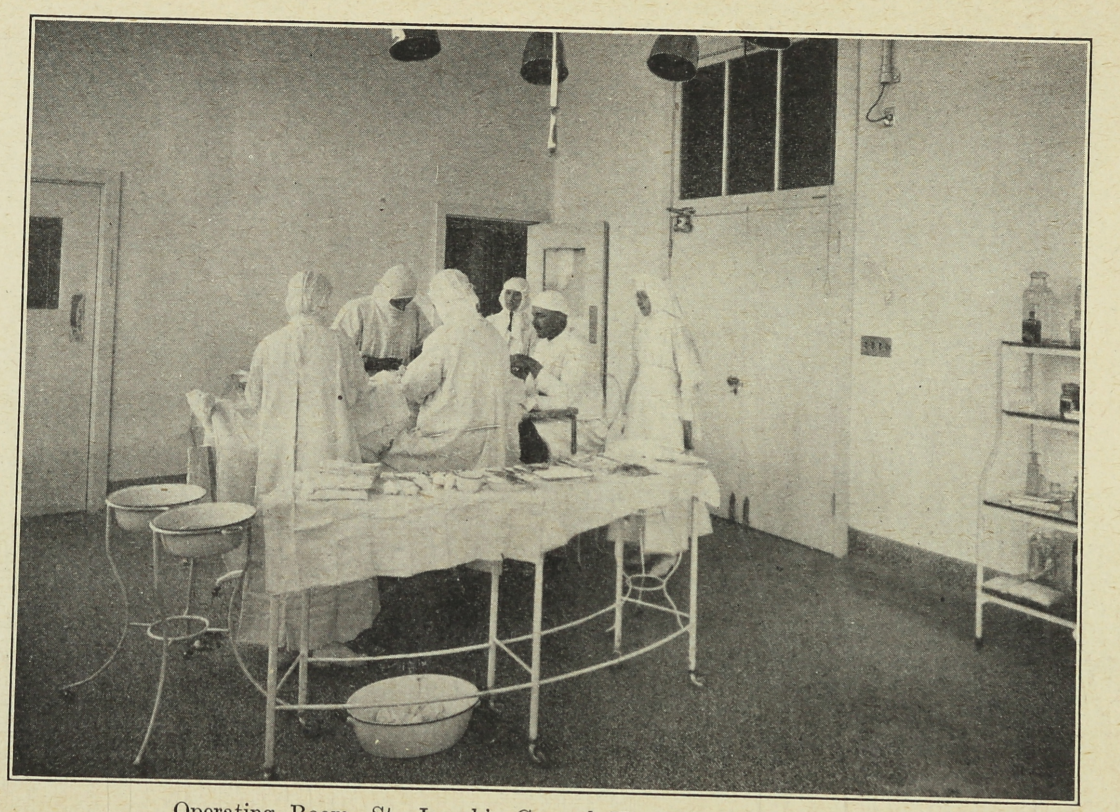
A committee formed to deal with this problem, at once sought the aid of the Sisters, knowing that the claims of the sick and suffering always find a responsive chord in the heart of a true religious. They were not disappointed. Immediately educational plans were abandoned for the time being, and the classrooms were thrown open to the numberless victims of disease. Day and night the Sisters worked to save those fever-stricken patients, and heroically combatted the terrible illness which threatened to depopulize the country. Finally their efforts were rewarded.

The people had come to value with proper appreciation the work of the Sisters, and to offer substantial acknowledgment of their services to the community. Land was donated and financial assistance was generously given toward the erection of their first hospital, a two-storey building with accommodations for about thirty patients.

So numerous were the daily increasing demands that six years later facilities were taxed to the utmost. Increased floor space became imperative, and in 1900 a new wing was added, almost doubling the capacity of the hospital.

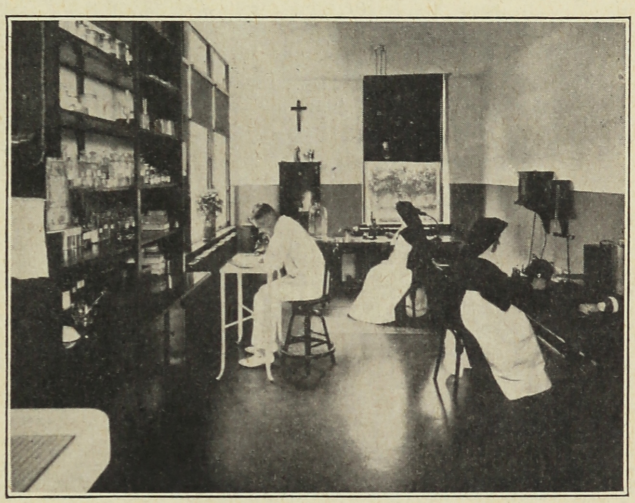
Despite the hardships and reverses which invariably accompany new foundations, the growth of St. Joseph's kept pace with the flourishing town of Port Aruthur. In 1904 it again became necessary to enlarge conveniences, and a second addition, containing a number of private rooms and several large wards, was added.

*We acknowledge with thanks the loan from *Hospital Progress* of the halftones illustrating this article.



Operating Room, St. Joseph's General Hospital, Port Arthur, Ont.

Care of the patient had always been the prime aim and interest of those connected with the institution, and as the hospital idea grew and developed, its worth and function became tested and broadened, its utility more pronounced, its possibilities and responsibilities greater. The administration and professional staff realized that a new era had come. The institution had outgrown its bounds. Science and modern



Laboratory, St. Joseph's General Hospital,
Port Arthur, Ont.

surgery demanded new accommodations, and plans were made to erect a hospital building which would meet all demands for years to come.

The building was begun in 1914, a short time after the Great War was proclaimed. For some time this seriously interfered with its progress. But the work slowly continued even through that period of financial distress and business depression, and the new division was completed and was dedicated by the Right Reverend Bishop Scollard.

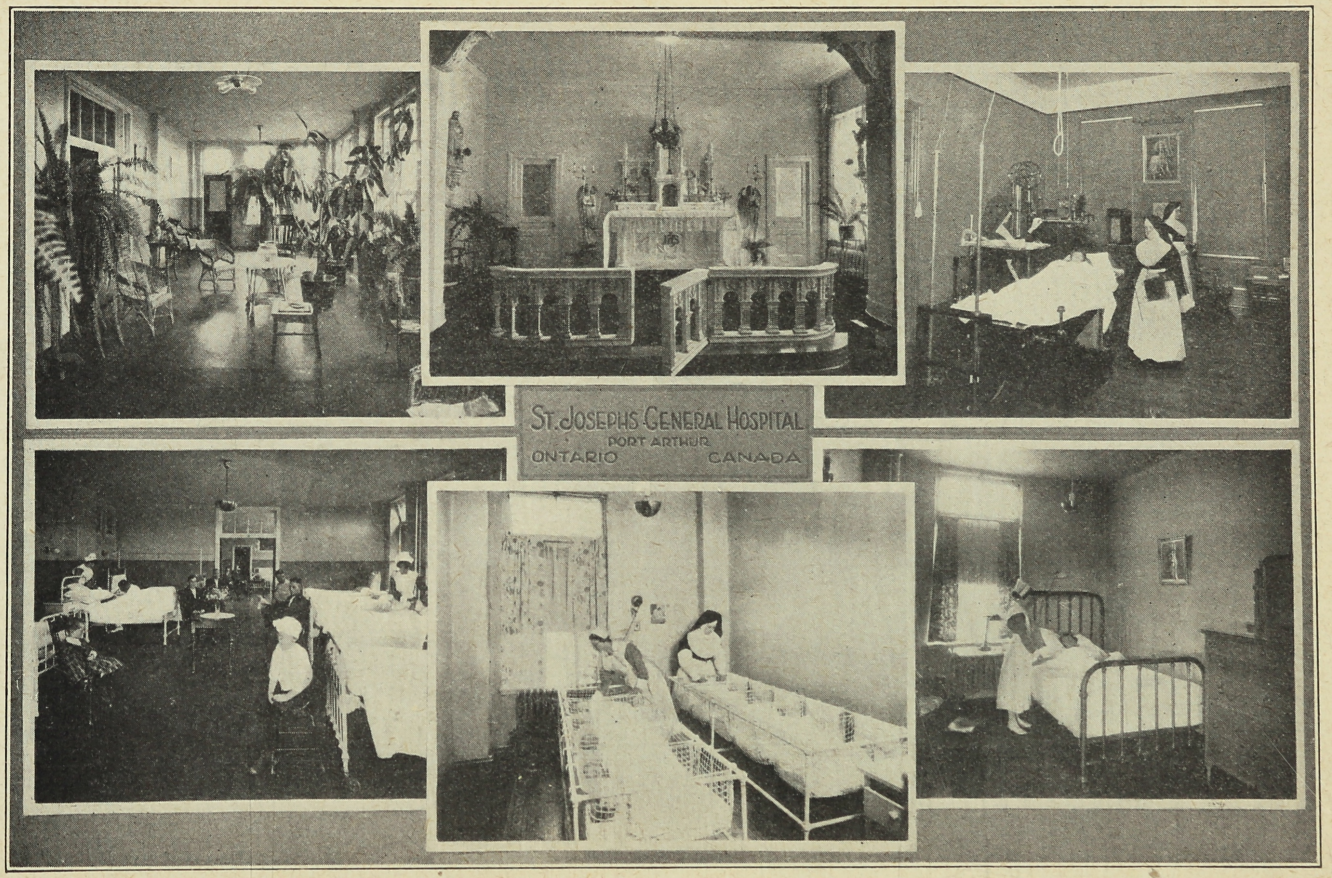
The building embodies the latest and best ideas of scientific arrangements, convenience, and sanitation. Proper ventilation, lighting, fireproofing, and effective heating have been kept prominently in mind. The location of rooms, offices, laboratories, pharmacy, elevators, etc., has received similar special attention, to provide the greatest hospital convenience.

The new wing is a five-storey building of reinforced concrete and red pressed brick, with a frontage of seventy feet on Algoma Street, and one hundred and twenty-five feet on

Sun Parlor

Sanctuary of Chapel

X-ray Laboratory



Surgical Ward

Nursery

Private Room

Interior Views of St. Joseph's General Hospital, Port Arthur, Ont.



Exterior of Hospital Building, St. Joseph's General Hospital, Port Arthur, Ont.

(We regret that so much of the Convent showing, hides a full view of the hospital)

Cameron Street, the entire hospital having a frontage of one hundred and fifty-five feet on Algoma.

Noiseless sanolite flooring in the corridors and wards adds greatly to the quiet and comfort of the patients. The corridor on each floor terminates, at the south end, in a beautifully furnished and decorated sun parlor. Diet kitchens, modernly equipped, prove a helpful convenience in serving the patient with hot, appetizing meals.

The first and second floors are entirely occupied by medical and surgical patients. The third floor is given exclusively to obstetrical patients and is completely fitted up for that purpose. The fourth floor comprises the suite of operating rooms, two large rooms for major surgery, a specialist's operating room, dressing rooms, wash-up rooms, shower baths, and linen rooms. The sterilizing room, equipped with high pressure steam sterilizers, etc., is situated between the two main operating rooms. The surgeries have the most complete and up-to-date appliances to meet all the demands of modern practice.

The clinical laboratory, situated on the first floor, is fully equipped with the proper facilities for carrying on the work of clinical microscopy, also bacteriological and pathological examinations. There is a pathologist in charge, with a Sister-trained technician. Urinalyses, blood counts, differential stains, widals, blood cultures, bacteriological work, fixing and staining of pathological tissue slides, and Wassermanns are done. In connection with the laboratory, a post-mortem room is properly fitted up for autopsies.

Directly opposite the clinical laboratory is the X-ray laboratory, fully equipped with the latest improved types of X-ray apparatus for radiographic, fluoroscopic, and treatment work. Two other machines have recently been installed, a dynelectron and a quartz lamp for physiotherapy work. Complete records are kept of all patients entering the institution.

A few years ago, when standardization of hospitals became a national demand, the management realized that new means and methods of procedure would have to be adopted to meet the accepted standards of practice, and to this end united effort was necessary. The professional staff heartily entered into the work and generously co-operated with the hospital authorities to accomplish the high ideals which all knew to be for the common good.

In 1922 St. Joseph's was listed among the approved hospitals of the United States and Canada. It has been pro-



One Class of Nurses in Training, St. Joseph's General Hospital, Port Arthur, Ont.

nounced, in point of population of the city, one of the best and most completely equipped hospitals in Canada.

To those familiar with the history of the institution it seems that so much has been accomplished in a comparatively short time, due to God's great blessing on those who labor for His suffering children; the kindly united efforts of the professional staff to further hospital interests; the generosity of the citizens of Port Arthur and the surrounding country who have never failed to offer material assistance; and the faithful Sisterhood which inaugurated and preserved this great work.

SYNOPSIS OF HISTORY OF HOTEL DIEU HOSPITAL, QUEBEC, QUE.*

L'Hotel Dieu, of Quebec, traces its origin to the Hotel Dieu of Dieppe, France, where, as far back as the year 1155, nursing sisters (religieuse Hospitaliers), devoted themselves to the care of the sick under the rules of St. Augustine.

In 1632, when England returned Canada to France, after occupation from 1629, the Jesuit Fathers returned to Quebec, and in their reports which they forwarded to France, deplored the lack of a hospital in Quebec—finally, though the pleadings of Father Paul Lejeune, head of the mission in Canada, the Duchess D'Aiguillon, niece of Cardinal de Richelieu decided to found a hospital where both French and Indians could be cared for. The Duchess in turn appealed to the Augustine Sisters of Dieppe, and betwen them a contract was signed on the 16th of August, 1637, for the foundation of a hospital with an endowment of 1000 francs.

The same year, workmen were sent to clear the land purchased on the outskirts of the city, also a piece of land within the city limits where the Hotel Dieu Hospital stands to-day. The foundation stones of the first hospital in Canada were laid August 12th, 1638, and were dedicated by the foundress on the 4th of May, 1639—three Sisters were sent from the community in Dieppe to help the Canadian hospital. They arrived in Quebec the beginning of August, but as their hospital was not yet completed, they were obliged to live in a large building, property of the Company of One Hundred Associates. In this building, shortly afterwards, they had to nurse a great number of Indians, victims of smallpox; in a very short period there were over 200 cases, with twenty-four deaths, in spite of the great attention given them. The survivors were

*We acknowledge receiving this article through the courtesy of Johnson and Johnson, Montreal.

greatly frightened and called the Hotel Dieu, the "House of Death." In the spring of 1640, the scourge followed the Indians to the woods and disease attacked other Indian tribes; they implored the Sisters to go and establish themselves near their settlements at Sillery, near Quebec; the Sisters readily consented, as they earnestly desired the conversion of the Indians, and also, because their Quebec hospital was not yet completed. The Duchess D'Aiguillon was so well pleased with this action on the part of the Sisters, that she, with her uncle, Cardinal de Richelieu, increased the endowment to 40,500 livres tournois. This capital was invested in France, and for many years gave a yearly revenue of 4,000 livres ($800.) On the 9th of July, 1640, the foundations of the Sillery Hospital were laid, it being completed in the following year. Its ruins were visible up to 1878. In the year 1644, M. de Montmagny, Governor of Canada, finding it impossible to defend both Sillery and Quebec against the forcible attacks of the Iroquois, persuaded the Sisters to come back to Quebec. They came very reluctantly, and had to sacrifice and sell their beautiful property to a Mr. D'Auteuil, for 2,000 livres ($400). The buildings alone had cost 15,000 francs. On the 29th of May, 1644, they returned to Quebec, and, as the monastery and hospital started in 1638 were not yet completed, they took refuge in a humble shack in Lower Town; a few months later they took possession. The hospital and monastery were separate—huts were erected around the hospital for the Indians who could not be accommodated in the hospital. On Oct. 15, 1654, the corner stone of a new hospital adjoining the monastery was laid, and was occupied, Aug. 15, 1658.

In 1672, M. L'Intendant Talon, a great friend of the poor, built a wing for men, and installed a plentiful water supply, which in those days was a great expense—a luxury.

In 1696, the present monastery was started; it was completed in 1698.

June 7th, 1755, at noon, in an hour's time, the Hotel Dieu, of Quebec, was in flames from one end to the other. The fire had one victim, one of the Sisters; the patients were all saved. The fire was set by a discontented, angry French sailor. The walls of the building resisted the fury of the flames. The Sisters found shelter at the Ursulines. The Jesuits also put their college at their disposal for a hospital until August, 1757, on which date the monastery had been rebuilt. Their extreme poverty now prevented them rebuilding their hospital immediately, and the basement of the re-built monastery was used for this purpose until Nov. 8, 1825.

In 1759, during the siege by the English, the Hotel Dieu was vacated on the 13th of July, and the Sisters sought refuge outside the city and did not return until the surrender of Quebec by the French.

From 1760 to the year 1785, or for twenty-five years, all the east wing of the present hospital to-day, was taken by the English for their invalided troops, whom the Sisters nursed night and day without any remuneration from the English.

On the 22nd of May, 1800, the chapel and choir were started, and completed in 1803.

In 1825 they moved into the large new hospital started in 1816. An addition started in 1890, opened in 1892, is 300 ft. long by 50ft. wide, adjoins the old hospital and monastery.

The last addition, a wing for sick children, was built with funds supplied by the Hon. John Sharples and opened in Oct., 1907. To-day the Hotel Dieu is provided with all modern conveniences. The newer buildings form a rectangle with the old wings and give three floors and a basement, each 700 ft. long by about 50 ft. in width. It has 231 beds. The hospital admits all sick ((regardless of creed or nationality), excepting contagious disease and obstetrical cases.

THE FAIRY TALE OF STE. JUSTINE HOSPITAL

Alice P. Benoit

Secretary-Treasurer, the Ste. Justine Hospital Subscription Fund.

Once upon a time, and not long ago, on a cold November day in 1907, when the last leaves were falling from the trees like wounded birds, in a room of an old house, seven women, $87.11, a broken table, and a few chairs, comprised the setting for the introduction of the fairy tale of Ste. Justine Hospital in Montreal. The women were planning the building of a hospital for children, which was a hard task then. So many people thought that little ones could be well looked after in private homes, and that the hospitals for adults could just as well admit the serious cases of childhood.

Because there was something to fight against and because there were poor little suffering ones waiting to be helped and cured, a week after, one bed, one ton of coal, one sick child, and one nurse entered the house simultaneously, and the Ste. Justine Hospital was founded.

Little by little, like the child in the woods gathering flowers and walking toward the big castle, where the lights shine and the blue smoke of the chimney tells the story of the warming fire inside; and like the child fighting against the wind and

the cold, shivering and trembling from fear of the wolves, those workers of the first hour fought and feared and trembled, day after day, that the little ones under their care might not have all they needed. Like the child in the woods gathering flowers, they looked for alms and charity, and feared that the wolves would come to tear and destroy them. But the light of the far-away castle was always shining, and the smoke of the chimney was always there to remind them that some day would find a big fire inside to give warmth to the little suffering ones.

Mothers Praise the Work.

A few weeks after the foundation of the hospital, early in January, a medical board was organized; the out-door department was established in March, and numerous mothers bringing their little ones, were loud in their praises of the institution.

The old house situated on St. Denis Street soon became too small. The locality was noisy and the administration decided to look for another site. A larger house on Delorimier Street happened to be vacant. The space in front of the house, and the beautiful trees, gave a garden-like aspect to the hospital. The awakening of nature and the first perfumes of the month of May marked the second chapter of the fairy tale.

The first report of the medical board for the year 1908 gave the following figures: 175 children were admitted during the year, and 586 consultations were given in the out-door department. The second year, 266 children had been admitted, and 1,885 consultations were counted in the out-door department. With the increase of patients, the administration turned over the management of the hospital to a regular staff. "Les Filles de la Sagesse," asked to co-operate, consented to undertake the task, and seven nuns came from France to look after the little patients; a blessing for the institution. During the third year the inauguration of the chapel took place. The hospital had been incorporated two years before, and the fairy tale was growing more and more interesting every day.

The fifth report gave as statistics, 454 children and 4,492 consultations. Once more the administration looked for another home, but this time more than a house was needed. A parcel of land was bought in the northern part of the city, on St. Denis Street, and the central part of the hospital was built; the third chapter of the fairy tale.

The dedication of the building was held in 1914, when the new hospital had eighty beds. Within a few years it became crowded again, the beds were always filled, the waiting list

was near fifty or sixty, the out-door department with only small rooms was crying for more space.

The original workers, on behalf of the hospital, always faithful to the cause, decided to undertake a campaign to raise funds for the building of the first wing. For a whole month, during the fall of 1920, the patrons and the friends of the hospital worked to reach the aim of the campaign. The funds raised increased the ardent desire of the administration to build and to spread their field of activities. In the fall of 1922, fifteen years after the first meeting in the old house, the new wing was opened. The fourth episode in the fairy tale had taken place.

The hospital has 150 beds, the out-door department daily receives numerous little patients, and the different services are well equipped. Last year's report shows that 1,707 children were admitted, and that in the out-door department 15,465 consultations were given.

The new wing is a fireproof construction of five stories and a basement floor where the laundry, autopsy room, ice-plant, disinfecting room, and the boilers are located.

The entire ground floor is occupied with the out-door department, consultation office, waiting room, and operating rooms for the out-patients.

The first floor is for the private wards, the second for the surgical department, the third and the fourth for the nurses and the personnel. The pharmacy and the administration are on the ground floor in the central part of the building. The medical ward, the chapel, the skin disease department, and the department of diseases of the eye, are also located in this central part. Each floor is provided with complete service rooms. The operating room on the second floor is well lighted and well equipped, and the laboratory and the X-ray department have proved to be very useful.

A thing always to be guarded against in a children's hospital, the sudden appearance of a contagious case, has been provided for in the isolation department, preventing the outbreak of an epidemic. The contagious case is kept in the isolation room until he can be admitted into the special hospital for contagious diseases. Another department keeps the new-coming patients under observation until the diagnosis can be confirmed. The child is then transferred to the isolation department, or goes to the ward, as the case may be.

Every department in the organization of the hospital has been under the direction of women who have devoted themselves to the success of the institution without any recompense

whatever, other than the smiles of the little ones and the spiritual satisfaction of the accomplishment of good. From the opening of the hospital, all the sewing has been done by women who come regularly every Wednesday afternoon and spend many hours of their lives making garments and other things needed in a hospital of 150 beds.

A record department has been in operation for the last six years, with a nun in charge. The records and all the filing histories of the patients are kept in perfect order.

The social service is well organized and every case requiring further attention is followed up after its departure from the hospital. Inquiries made have proved very satisfactory, and in many cases are most useful to helpless little ones.

Co-operation has been secured through regular joint meetings of the board of administration and the medical board. The organization of the hospital has merited for it, recognition by the American College of Surgeons as a standardized hospital.

To-day, two years after the opening of the first wing, the hospital is again over-crowded. The bed capacity, which was originally intended as 150, is now serving 175. There are thirty-five nuns and forty-five nurses, and the hospital needs more help. The administration is looking forward to other achievements of the hospital, by building the second wing.

The fairy tale is not yet finished. Far away lights are still shining. But the wolves can no more threaten the child gathering flowers in the woods, for the little one has grown and become so strong that no evil can befall it. The institution has developed to one of power, a thing of kindness and charity, keeping close to its heart the little ones who suffer and weep.

It shall stand for ever, the hospital of the beautiful fairy tale.—*Hospital Progress.*

ERRATUM

In the review notice of "Hospital Accounts and Financial Control" by Joseph E. Stone, and which appeared on page 183 of the "May" issue of The Hospital World, we referred to the Macmillan Company as Canadian agents. This is incorrect; Sir Isaac Pitman and Sons, Limited, the publishers of this splendid book, have their own offices for the Dominion, the same being part of the Macmillan Building, Bond Street, Toronto.

Society Proceedings

ALBERTA HOSPITALS ASSOCIATION

This Association held its 1924 meeting in the Macdonald Hotel, Edmonton.

After the opening Mr. W. T. Henry touched on the subject of hospital support, comparing voluntary support with that by the taxpayer. He admitted that people were likely to take a greater interest in institutions which they voluntarily supported, on the principle that where one's treasure was, there the heart was also; on the other hand hospitals were more easily financed when done by the municipality. The Royal Alexandra Hospital was an example of the latter-named method.

Dr. Lafferty thought there should be more uniformity among hospitals and a proper standard made in respect to Government reports.

Mr. Whiston, referring to the summary sheets issued by the Provincial Department of Health which hospitals were required to fill, stated that information from certain hospitals was incorrect. He hoped hereafter information asked for would be exactly right.

Mr. Dutton criticized the form of the summary sheet, claiming that certain of the questions lent themselves to a variety of interpretations. Different hospitals answered the same question in different ways. The form should be revised. One of the bones of contention was that referring to the percentage of deaths following operations. Calgary General Hospital showed one per cent., while the Royal Alexandra at Edmonton showed six. There must be something wrong in the computations. He understood that some hospitals included minor operations as well as major in their reports; while others did not. Again, in respect to forms representing the finances, these, he maintained, did not show the real financial standing of any particular hospital.

Dr. Smith, Superintendent of the Royal Alexandra Hospital, criticized form 102, as being cumbersome, useless and requiring hours to fill.

Mr. Henry suggested that a committee be appointed from the representative hospitals to revise these forms. There might

be two sets: one for the larger hospitals and another for the small.

Mr. Stickney, of Drumheller, suggested corresponding with the various secretaries of the hospitals, who would be asked to go into the whole matter—thoroughly and in a comprehensive way.

Dr. Washburn held that the per diem rate did not give any one any information. The departmental method of accounting was the only satisfactory one.

In reply to a question, Mr. Whiston said that it was the intention to cancel form 102. Following discussion a committee was formed to take up with Mr. Whiston the content of this form.

Dr. Gow called attention to the satisfactory manner in which the General Hospital at Calgary was financed. "The people are taxed so much and that is all there is to it." An endeavor is made to run the hospital as economically as possible. They receive no contributions.

Mr. Stickney introduced a resolution to the effect, "That all ratepayers in the province be taxed $8.00 each per year for health purposes." In his own district, a mining and agricultural one, there was a transient population,—many outsiders who came to work during the summer and fall. These men often fell ill and little or nothing could be received for their care. Mr. Stickney's motion was referred to the Resolutions Committee.

Mr. Whiston inquired why there should be two hospital associations in Alberta. Could they not be brought together?

In response to his suggestion a committee was formed to bring the question on union before the Municipal Hospital Association.

A delegation from the Alberta Association of Physicians and Surgeons was then received, who submitted certain changes in the regulations of the Hospitals' Act, which they had decided upon at the request of the Hospital Association. The delegation hoped their recommendations would be approved by the Hospital Association and forwarded to the Minister of Health.

Dr. Smith reported that there was a balance of $500 in the treasury. He thought the amount of the annual fee might be lessened. At present the fees, according to Mr. Henry were: Twenty-bed hospital, $10; twenty to fifty beds, $20; fifty to one hundred, $30; one hundred and over, $50.

Father Cameron moved the fees be cut in half. Carried.

Then followed Dr. Thos. Whitelaw's paper on "The Problem of the Aged and Incurable in Our Community." There were some eighty incurables in Edmonton alone. Such cases were unsuitable for general hospitals. The province ought to provide a home for this class.

Dr. Washburn proposed that Dr. Whitelaw's paper be forwarded to the Department of Health for action. Agreed. He hoped the Association would endorse his expression of appreciation of the work of the Salvation Army in helping the aged, infirm and indigent of the community. The Army had a splendid organization for assisting hospitals, particularly in the matter of indigents arriving in the city.

Mr. Stickney drew attention to the fact that Alberta was the only province west of the Great Lakes which had no institution for incurables. One had recently been built in Saskatoon, where (as well as at one in British Columbia) the cost was $1.25 per day,—much cheaper than the cost in hospitals. In Manitoba and Saskatchewan the municipalities from which the patients come pay fifty cents per day; and the Government provides the rest of the funds. In British Columbia the municipalities pay $1.10 per day. In addition they are expected to pay fifteen cents per day toward capital cost.

Dr. Thos. Whitelaw, in supporting the project that Alberta should have such a Home, suggested the name "Eventide Home," as is done in the Old Country, where the majority of inmates are indigent, aged or incurable folk.

The next session was held in conjunction with the Alberta Resistered Nurses' Association; and a paper was read by Miss Clarke, entitled "Public Health Work in Alberta."

Replying to a question, Miss Clarke stated that the staff consisted of six district and eight public health nurses. A public health nurse must be a graduate in the course of public health nursing given by the University of Alberta.

Miss Kelly thought those nurses who were sent to country districts should have had a special course in obstetrics.

Miss Clarke said that during the past year they had placed four nurses on the staff who were partially on a paying basis, since some people preferred to pay something for services rendered.

Miss McLennan read a paper entitled "The Organization of a Dietetic Department."

In reply to a question, Miss McLennan said that students in dietetics were given sixty hours of laboratory work.

Miss Randall inquired how smaller hospitals did, where dietitians were not employed. Miss Welch said at Lamont

they had a dietitian who had taken about half the regular course; this official, with the superintendent of nurses, managed to cover the work. She had found the course of twelve lectures given by the Women's Institute very helpful.

Miss E. McPhedran read a paper, entitled "The Importation of Registration of Nurses in Our Province."

Discussing this paper Miss Randall pointed out that in a question of legal liability the hospital standard of the doctors always counted. Were they registered practitioners? It would be of similar advantage to hospitals if they could say that responsible nurses were registered.

In reply to a question Miss McPhedran stated that only nurses from hospitals having a registered nurse in charge were eligible for registration. In British Columbia the Health Department more and more were stressing the importance of having only registered nurses in charge of hospitals.

Dr. Gow read a paper on "Hospital Supplies."

Dr. Smith, of Edmonton, in discussing this paper said the first thing to do was to buy what you need, not merely what you thought you needed or what somebody tried to convince you you needed; to buy at the right price, and not buy in too large quantities. The next thing was to see that waste was cut down to the minimum, which was a difficult thing to do, seeing that many supplies pass through so many employees' hands. A certain percentage of employees seemed to take pleasure in seeing how much they could waste.

Dr. Gow said there had been a great saving of drugs in his institution since the introduction of a hospital pharmacopœia. He believed in Manitoba where they had co-operative buying much good had been accomplished.

Dr. Washburn thought the usefulness of the co-operative buying project was limited. Personally he had found it difficult to satisfy the doctors in supplies they required. Some of them threatened to send patients elsewhere unless their whims were gratified. He held that physicians were demanding too much of hospitals, especially in the way of instruments. He had found that no matter how many supplies were issued they all seemed to be used. He had adopted the policy of restricting issues to bare needs. He liked the idea of a purchasing agent. The offices of purchasing agent and stock-keeper might be combined.

Miss Randall then read a paper on "Training School Inspection in British Columbia."

Discussing Miss Randall's paper Miss McCallum said she hoped to see Hospital Inspection of Training Schools instituted in Alberta before long.

Miss Randall in reply to a question, said she was Registrar of Nurses in British Columbia and also Inspector. She gives half time to this work. She visits schools about once a year; but if a superintendent moves she usually makes a second inspection.

Miss Randall, asked what she thought about hospitals allowing their pupil nurses to do special duty for pay which the hospital collected, decidedly disapproved of this practice. It was not right. In reply to another question, Miss Randall said that in British Columbia they had not established an eight-hour day, but had made a regulation that nurses must have two hours recreation and an hour for class work and an hour for meals daily. Generally speaking, this gives about eight hours a day. They were not able yet to arrange a similar period for night nurses. In one hospital no pupil nurses are taken on the wards from September to May. This is an ideal plan. These nurses get plenty of experience and are able to go to class work with the rest of the students. Some schools are obliged to be a law unto themselves.

As to salaries paid to pupil nurses, Vancouver General allows them six, eight, and ten dollars per month. Most Roman Catholic Hospitals give six to eight. Some of the smaller hospitals are obliged to go as high as twenty. Some nurses would prefer Vancouver at ten dollars than other hospitals at twelve or fifteen dollars.

As to supervision of nurses' homes, Miss Randall said there should be some one to see that the nurses are all in their beds betimes. If there is any one ill at night there should be a matron to see that she gets proper attendance. Some superintendents think, in so far as discipline is concerned, they can get on with monitors.

Superintendents of hospitals should have extra time for class work. In all the bigger hospitals there should be one nurse to two and one-half to three patients. There must be at least two graduate nurses in every hospital. Where there is a training school, there should be three: a superintendent, a night superintendent and a third to relieve. Special nurses should not serve more than twelve hours a day. This was the limit.

Dean Kerr, of the University of Alberta, read a paper on "The University Education of the Nurse."

Discussing Dean Kerr's paper, Miss Randall stated that all nurses should matriculate. The field was already overcrowded,

so the standard should be raised. The standard for matriculation was a two years' high school course. To become teachers girls must pass through the high school and normal schools as well; but no one has been around to tell the family that any special education is needed for the daughter before she starts to train for a nurse. Representations should be made to the Women's Institutes and the Parent-Teacher Associations advocating matriculation before entering the training schools. This for their own protection.

Dr. Smith, Edmonton, called attention to the action of the Minimum Wage Board in its inquiry into the question as to whether nurses should be classed as other workers who belong to Trade Unions. An endeavor was made to convince the Board that the Nurse Training School was a college, not a workshop; that it was on the same basis as a high school. It was only when they saw this that they decided to allow nurses to fix their own standard of wages. Approach had been made by the Alberta Association to the Department of Education asking that Department to recognize the Training School for nurses in the same sense as they had recognized high schools and colleges, and recommendation was made that a grant be made to Training Schools, so much a year for every nurse attending. No result had been achieved as yet. Dr. Smith hoped the present Convention would endorse the movement.

Father Cameron then presented a paper on the "Spirit of the Hospital."

In discussing Father Cameron's paper, Dr. Smith said there was too great a tendency in these days to emphasize the material and financial sides of hospital work and to put too little stress upon the real object for which the hospital exists.

Miss Fellows read a paper on "The Problem of the Private Nurse."

Miss Kelly in discussing this paper said that according to her experience the private duty nurse was one who lives in a suit case. She had many hardships. She was unable to rest in the patient's room when the patient was restless; she often had to undress in some place in the basement with no chair to sit upon and had to charge through the hospital corridors in her kimona. She could not get a bath in the bath room; she was never sure when she would be off duty. She perhaps got off at eleven o'clock and had an hour's run before reaching home. If she was not in at six she missed her supper, and had to pay for it outside the hospital. In some hospitals she was obliged to carry her dishes to the kitchen and wash them. In some

places the soup served to the nurses was suggestive of dish-water and the stew suggestive of the pail beneath the scrap table.

Miss Kelly could not agree with the reader of the paper when she maintained that the private nurse was a luxury. In the home where there is a very sick patient the private duty nurse is a necessity. Special nurses in private homes by their demeanor and conversation were incidentally teaching the family how to prevent sickness and to maintain health.

Miss Randall held that hospitals should remember that when a private nurse comes on duty the hospital was being saved a student nurse but was charging the patient for a certain amount of nursing; hence was under the obligation to furnish a nurse during the absence of the special at meals and during hours off.

Miss Fellows said that if it was declared that the special nurse was a necessity in the hospital it was a reflection on the hospital management. Indigent patients are always given sufficient nursing without the invasion of special nurses.

A round table conference was conducted by Mrs. Manson. She informed the Association that nurses who had graduated from a regular training school and had received diplomas therefrom were obliged to write off another examination set by the University of Alberta before they could receive the degree of R.N. Would it not be possible to combine these examinations?

Miss Auger (Medicine Hat) replied by saying that if training schools and text-books could be standardized, it would be possible to have but one examination, and that by the University. The practical side of the examination could be held in the training school; each local hospital might estimate the nurses' practical work during the three years' course. As to the first and second years' examinations, should these be set by the University? If conducted by the training school would the results count in the final rating? If the local training-school examinations were done away with, there would be a lessening of the control of the training school over its pupils. Miss Auger thought they were not ready yet for the one examination; but it was an ideal toward which they might work.

Miss McCallum suggested that the examinations might be held in the training school by examiners sent out and paid by the University.

Miss Randall thought they must come to recognize provincial-wide standards of education; they must get away from the local idea. She agreed as to the importance of standards in schools and text-books; and there should be a standard for

the women who conduct the schools; women must be secured who are capable of carrying out a proper educational system. Miss Randall pointed out that the markings of the doctors and of the superintendent of nurses who set the training school papers were usually much higher than the University markings.

Father Cameron said if it was proposed to standardize bodies of pupils it would be absurd, if the University is to set the examinations, that another organization should inspect the training schools. There were, it seemed to him, two divergent ends in view, both of which could not be attained. He would not like to see the sentiment of loyalty of the nurses to their alma mater discouraged, which would occur if too much authority were taken away from the superintendent of the training school and handed over to a non-interested institution.

Miss Randall, answering the last speaker, said that the inspector of training schools in a province properly organized, would come under the jurisdiction of whatever department looked after educational matters. In British Columbia the nurses were obliged to do this work. She did not think the nurses' spirit of loyalty would be lessened by having to pass an examination set by an outside Board of Examiners.

A visiting delegate stated that in Scotland there are held half-yearly examinations by the Local Government Board, held at four examination University centres. The candidate nurse requires a doctor's certificate to the effect that she has taken fifty per cent. in the training school examinations. She pays her own expenses to the centre where the examination is held. Her final examination is given at a hospital in one of the examination centres where she is examined by four doctors and two matrons chosen by the Local Government Board, which Board gives the diplomas.

"The Employment in some Hospitals of Third Year Students as Special Nurses." In discussing this subject Miss Randall said she had been able to have this system abolished in two hospitals in the United States with which she was connected. She had only learned at the National Association meeting some two years ago that such a thing was countenanced in Canada. Then a resolution was passed protesting against pupil nurses doing special duty in a hospital and the hospital accepting money for such service. She had never heard one good argument in favor of such a practice. One argument had been brought forward by some people that doctors preferred student nurses to graduates, where specials were required. If that was so something must be wrong with the school. The Ontario Registration Board had passed a wise rule in that they

allow nurses to have not more than two months private duty in special nursing, but the hospital must not charge for the service.

Father Cameron thought the Government should make a subsidy to training schools. He believed if a nurse went into a hospital with the understanding that the hospital might charge for her services as a special, that was her business.

Miss Randall in riposte said there was nothing gratuitous about the education of the nurses. To say that any woman does not give sufficient dues to the hospital for the education she gets is a very open question. In some hospitals nurses do not get a proper amount of nursing education; but are simply used for the benefit of the hospital. The association must look after the interest of the pupil nurse in so far as education goes.

Miss Fellows pointed out another objection to the practice of employing pupil nurses as specials: it would lessen the number of jobs for the graduates.

Dr. Smith said he would like to see this matter settled definitely, one way or the other. Some hospitals save a considerable amount by employing their pupil nurses to do special duty and charging the patients for the extra service. He did not think the question had anything to do with the training school at all, since in every hospital there was always a number of very sick patients in the public wards who required individual attention, and they always got it. As a matter of fact there seemed to be too much specialling. Dr. Smith's own view was that no hospital should charge for the service of their undergraduate nurses.

Father Cameron held that where a nurse has a patient under her own charge and is given the sole responsibility of the case that is as much a part of her education as is the work of the nurse in the public wards who has two or three cases to look after. Certain private hospitals find it a great help to be paid for this special work of their undergraduate nurses. It was easy for superintendents of hospitals whose whole support was from taxes to decry this method of raising money.

Dr. Washburn thought Father Cameron was right to a certain extent, but the thing was not wholly proper. If any charge was made for undergraduate specialling the money should go to the support of the training school.

"The Advisability Both in the Interest of the Patient and of the Hospital of an Approved List of Surgeons for Major and Minor Operations in all Large Hospitals of the Province." Father Cameron opened the discussion on this subject. At present, he said, every doctor in a community is a member of

the medical staff and there is no way in which a hospital can prevent any doctor on the staff from performing major operations; and many doctors were doing major operations. He had been informed that in some parts of the province twenty per cent. of the deaths in hospitals take place after operations; which means if a patient went into a hospital for an operation there was one chance in five of his life being snuffed out. He strongly favored the idea of hospital boards having an approved list indicating what surgeons were considered competent to do abdominal operations. The trustees might be advised by the Medical Advisory Board as to the selection.

Dr. Washburn said it was not difficult to make out such a list of such qualified men. It was folly to suppose that the young graduate fresh from college was competent to do major surgical work. To be able to do this necessitated post-graduate study in one of the best clinical centres. In his hospital Dr. Washburn said the sugeons held consultations before operations. This was a great step in advance and tends to much better surgical work. The closed hospital staff was not the hardship on the profession some of its members thought it was.

"How Are Patients Admitted to the Hospital and How Are Visitors Dealt With?" Dr. Gow answered this question. He described the procedure at Calgary General Hospital. Patients are admitted only through a member of the staff. The nurse in charge gets the name of the patient, ascertains the kind of accommodation wanted, the nature of the trouble and when the patient wishes to come in. The nurse then advises the doctor if there is room for his patient and if so reserves a bed. On the arrival of the patient, all particulars needed are taken at the office (unless the case is an emergent one) and the patient is taken to the ward, when he is put to bed, his temperature taken and the attending physician called. The doctor's instructions are written in an order book. Then the patient's clothes and other belongings are taken from him; he is given a bath, sponge or tub as ordered by the doctor. His clothes are kept in the ward, but his valuables are taken to the office.

With respect to visitors, Dr. Gow said their custom was to allow the patient to see visitors just previous to operation and after coming out of the anesthetic; also on the following day. The Clergy and Sick Committees were allowed in at any time; and friends are allowed in when the patient is on the danger line. Every consideration is given to visitors so long as it does not interfere with the duties of the nurses. People from the

country districts are given special consideration—a privilege sometimes abused.

As to telephone inquiries about the condition of the patient, this requires much discretion and common sense on the part of the official at the hospital, whose duty it was to give out such information. When the patient's condition was serious information respecting his condition was given directly by the head nurse in charge of the ward.

Miss Randall said that in her experience if visitors were allowed into the wards every day nurses found it easier and friends found it a great consideration. It did not disturb the wards as much as one would think. Two hours were allowed each afternoon and one hour in the evening.

Mrs. Manson described how much the nurse could do toward relieving the anxiety of a new patient by a little kind consideration immediately after the patient is admitted. Miss Randall corroborated this view, calling it "the key-note" in the admittance of patients. Superintendents, head nurses and pupil nurses should all feel that they are hostesses of a sick guest. People from the countryside often have a great fear of hospitals. Such patients should be made to feel at home. This sort of welcome is not only a courtesy, but is of therapeutic value. In the past hospital officials had probably stuck too closely to rules and regulations.

Miss MacCallum said that in her hospital they had a great many people from the country—patients who had not had the opportunity before leaving home of having their clothes ready or of taking a bath. Her hospital had fitted up a small room in a nicely finished basement which was now used as a bath and wash room in connection with the admitting work. There was a cupboard built around the room for the storage of the patients' clothes. They had separate bags which contained the clothes. All the underwear was washed. They had an old lady in charge of this room, who even goes so far as to darn the socks of the patients. Private patients, of course, do not go through this room; but all children and all public ward patients pass through it. The patient is examined by the houseman who decides what sort of a bath the patient is to be given. Three clothes' lists are made out—one for the ward which goes with the slip from the admitting office, recording temperature, pulse and respirations and anything else observed by the admitting nurse who looks after the bathing; one is pinned to the clothes, and the third goes to the business office with the valuables. The slips are signed by the admitting office and by the ward nurse and serve as receipts. They had

received much praise from patients in respect to this careful method of taking care of patients' belongings. All emergency cases went direct to the wards or operating room.

"What Is the Role of the Physician in the Education of the Nurse?" Miss M. M. Black, of the University Hospital, Edmonton, answered this question. This query was an intimation of the brotherhood and the sisterhood of the medical and nursing professions. The first contribution the physician makes is that of instruction and the second that of medical and scientific research. Indirectly he makes a contribution by the force of his example, and by his co-operation. The physician may be said to be the backbone of the health of any community. Physicians have given unsparingly of their time in teaching in the training schools. Many of them had excellent methods and were able to create an intelligent interest in the subjects taught. Certain physicians, it was to be regretted, owing to outside interests, were lax in keeping appointments of their lectures in the school. This might seem unimportant to them; but it works a great inconvenience to the student nurses who have no leeway of time for their engagements. The chief weakness in the teaching of the physician was in failing to stress the preventive side of medicine. He was often in too much of a hurry to speak of the curative side. The speaker was in favor of securing paid medical instructors, men who would recognize the necessity for a strict adherence to the school schedule. Such instructors should see clearly the importance of teaching preventive medicine. Nurses should be taught not only to recognize symptoms and methods of cure but should also be able to recognize symptoms and conditions of incipient disease and learn to combat them before the more advanced disease sets in. Hence the importance of the hygiene of childhood, prenatal care, etc.

Miss Black holds that nursing is a distinct and essential branch of medical science and must develop side by side with medical practice. Physicians do not always recognize this and are at times disturbed by the attitude of progressiveness of nurses. Physicians should inspire nurses with ideals and the spirit of modern science. They should help to enforce not only the theoretical side but also the practical side of scientific training. Men of high training and with convincing and inspiring personalities ought to give nurses the larger vision. Doctors should advise, help and co-operate with nurses individually and collectively in their desire for a higher elementary knowledge and a more thorough school training.

Mrs. Manson thought doctors should help those in charge of nurses to rectify any mistakes made by nurses.

Miss Randall thought doctors should use the clinical material in the wards for the benefit of the student nurses. Too often there was a lack of co-ordination between the lectures and the practical work. Theory and practice should go hand in hand. The patient in the ward should be the centre of class work.

Dr. Washburn believed that the instruction doctors give to nurses is too indefinite and that they do not go into details sufficiently. He was not in favor of physicians giving instruction. It should be given by nursing instructors.

Dr. Smith thought that in the past seventy-five per cent of the instruction given nurses has been given by medical men. If the success of the nurses in the R. N. examinations was a criterion of the thoroughness of their training, they owed a great deal to the doctors' teaching. He agreed that qualified instructors should be employed for this work. But all instruction should not be given by them. The training school should retain a very close association with those who are practising medicine.

"How Best to Develop and Operate the X-ray and Pathological Laboratory Work in the Rural Hospital." Miss Howard, of the University Hospital, discussed this problem. In installing an X-ray outfit in a rural hospital the first thing to consider was electricity. If the town can supply 110 volts, alternate current, the matter is a simple one. If the hospital generates its own power the proposition is more difficult and extensive, since a converter must be attached to the X-ray plant in order to give the necessary alternating current for the machine.

The X-ray room and the dark room should be on the same floor and near the operating room, since many fractures had to be rayed. It was a good plan to have the operating room wired and provided with special plugs, so that the machine could be attached. Thus plates could be taken without disturbing the patient, saving an extra move before the plaster and splints have been finally adjusted. The X-ray room should be large enough to hold the X-ray table, the machine, a chair and a box 20″ x 20″ x 12″ lined with a layer of lead one-eighth inch thick, in which the films may be kept while the rays are turned on, lest they become fogged.

The fewer people in the X-ray room during the picture-taking the better. The windows should be fitted with tightly fitting shutters, the edges being covered with felt to exclude

all light; so also with the dark room, which should be somewhat remote from the X-ray room, since the rays penetrate through two or three walls and fog the films. Necessary shelves should be constructed. If possible there should be running water for the developing tanks. The companies supply these tanks or they may be purchased separately. They may be made of enamelled iron 20″ x 20″ x 10″—one for developing, one for fixing and one for washing the films. A work table and ruby light are also necessary.

If the operating room work is not too heavy the nurse in charge may have supervision of the X-ray in so far as treatment is concerned.

As to the laboratory, there should be at least two windows in the room set aside for this purpose. These for light and proper ventilation. There should be running water, closed cupboards for jars, bottles and specimens, a table facing a window for the microscopic work (also an artificial light). And there should be sufficient equipment for routine examinations of blood and the excretions. A considerable amount of bacteriological work may be done for the smaller hospitals by the health department in their laboratories. There should be enough equipment for doing the work connected with the investigation of nephritis and diabetes. The efficiency of the laboratory depends mainly on the person in charge.

Dr. Washburn suggested that in the country two doctors even might afford a Delco; or the small hospitals might have a small machine installed. The films might be forwarded to the radiologist of one of the larger hospitals in the city who would telephone reports back—a similar service to that given by the provincial laboratories when specimens were sent to them for examination. Radiologic technicians might be trained for the work in the smaller hospitals at the expense of the municipality. Dr. Washburn expressed the opinion that X-rays were used too much in the cities.

"Central Bureau of Information." One of the objects of such a bureau would be to convey information respecting patients who have the habit of going from one hospital to another without paying their bills. The records of the hospital in which a patient was first treated be passed on to any subsequent hospital taking care of him. Dr. Washburn recited a specific case, showing the value of such a bureau. Representatives from the various hospitals in the district might meet monthly to discuss ways and means of increasing collections. Common problems might be discussed and experiences cited. Concerted pressure could also be made on the Government to

take more seriously its responsibility in making provision for the care of the indigent sick.

Dr. Smith thought records of hospitals were not used as much as they should be. Generally speaking they were stored away, became covered with dust and liable to remain obscure for years, being put to little or no use.

"What Provision do Hospitals Make for Emergency Work?" Mrs. Welsh, of the Lamont Hospital says her hospital is never left without either the superintendent or her assistant. If the operating room nurse is away her senior nurse is ready for duty; and the operating room could be made ready in half an hour. There are three doctors in the town and there is always one on call for the hospital.

"Maintenance of the Training School." Miss Glurnsey read this paper. In reply to a question in discussion, the essayist said that the Mt. Sinai Hospital, New York, had a budget for the training school. It was found that the student nurse was worth $1.20.

Miss Randall said the correct cost of the training school could not be obtained unless one knew what the teachers were paid. One must consider how much time the superintendent of nurses gave to the hospital and how much to the training school. At present it was not known what the actual cost of maintaining a pupil nurse was.

Miss MacCallum thought that in certain American hospitals it cost the hospital $1,000 for each nurse in training.

Dr. Smith said that in Edmonton an attempt had been made to figure this out, but when it came to compute the value of the services of a nurse difficulty arose.

The following officers were elected for the ensuing year:

Honorary President, Hon. George Hoadley; President, Dr. R. T. Washburn; Vice-President, E. E. Dutton; Secretary Treasurer, S. V. Davis.

Executive: H. R. Smith, Dr. Gow, Father Cameron, H. B. Stickney, Mayor Herod, Lethbridge.

A committee on Government forms was chosen as follows: W. T. Henry, A. D. MacDonald, E. E. Dutton.

Legislative Committee: H. R. Smith, E. W. Stacey, A. E. Archer, E. E. Dutton, Dr. Young.

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2. Saving of time, eliminating short hitches.
3. Saving power by elimination of false stops.
4. Greater safety in handling passengers.
5. Less wear and tear on electrical and mechanical apparatus and subsequent reduction in maintenance cost.
6. Elimination of the necessity for skilled operators.

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AN UNUSUALLY LARGE GALLSTONE PASSED BY RECTUM

A. J. Gordon, Newark, N. J. (*Journal A.M.A.*, Dec. 20, 1924), reports the delivery per vias naturales of a gallstone weighing 139 grains (9 gm.). It caused terrific pain while passing down the rectum, and when the stone was about an inch or two distant from the anal orifice the pain was so unbearable that the woman had to insert her finger in the rectum and deliver the stone. The stone submitted was found, on examination by the American Medical Association Chemical Laboratory, to be a typical gallstone of unusual size.

REPAIR OF ACQUIRED DEFECTS OF THE FACE

The repair of acquired defects of the face by means of skin flaps is discussed by Robert H. Ivy, Philadelphia (*Journal A. M. A.*, Jan. 17, 1925). In his experience, in extensive deformities and defects of the alae of the nose, better results will be obtained by sacrificing these defective parts and entirely reconstructing them from a single forehead flap, rather than by making a patchwork nose in utilizing portions of shrunken alae and other remnants.

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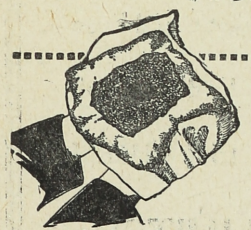
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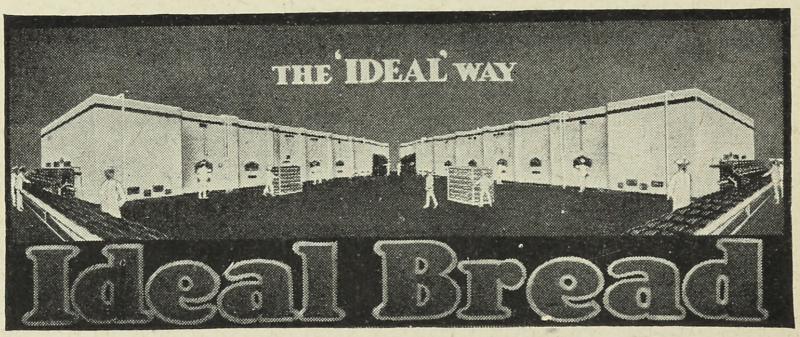
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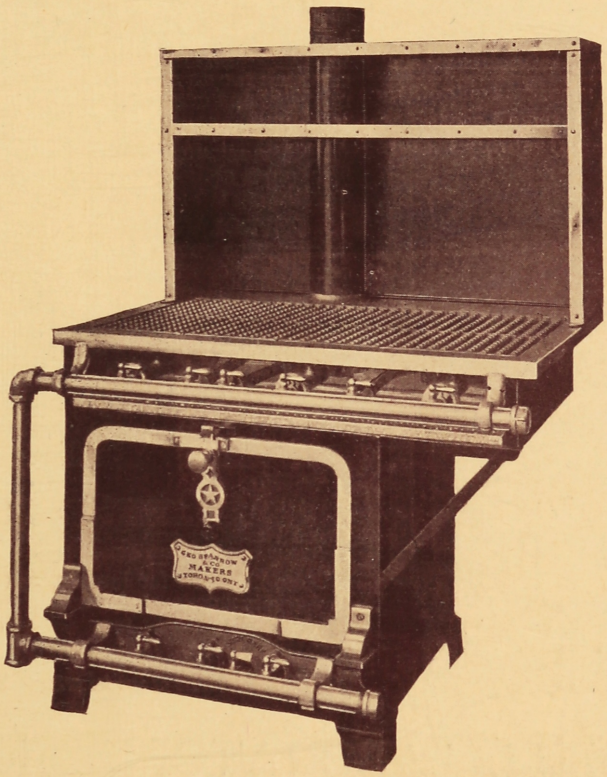


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